Binational Notification

Telephone: (619) 542-4013 Fax: (619) 692-8020

[1]Referring Jurisdiction: _____ [1]Date sent___/____/___
City County State

[1]Contact person: _____ [1]Telephone. ( ) _____ Fax ( ) _____

E-Mail Address: _____

☐ Verified case ☐ RVCT#: _____ ☐ Not reported ☐ ICE A# _____ ☐ History request
☐ Suspect case ☐ Close contact (Form CureTB 115) ☐ Immunocompromised ☐ LTBI ☐ Source case

[1]Patient name: _____ Sex ☐ M ☐ F
Paternal Maternal First Middle

Alias: _____ DOB: ____/____/____

[2]Address in Mexico: _____
Number Street Apt "Colonia" City

_____ [2]Telephone: ( ) _____
"Municipio" State Zip code

[2]Contact person in Mexico: Name: _____ Telephone: ( ) _____
Relationship: _____

Address in the U.S.: _____
Number Street Apt City

_____ Telephone: ( ) _____
County State Zip code

[2]Contact person in the U.S.: Name: _____ Telephone: ( ) _____
Relationship: _____

Clinical information for: ☐ this referred case/suspect ☐ Index case for this contact ☐ this contact ☐ not applicable
Site (s) of disease: ☐ Pulmonary ☐ Other (s) specify: _____

[1]Date of collection	[1]Specimen type	[1]Smear	Culture	Susceptibility	[3]Chest X-ray	Other tests/results

[1]Medication: ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Comments: _____

Expecting moving date to Mexico: ____/____/____

Patient given _____ days of medication

1. **Fields required to initiate the referral process**
2. **At least one address or phone number is essential to establish contact with patient after their departure**
3. **When smear negative, please describe Chest X rays results**

Whenever possible send official CXR reports and laboratory reports as attachments to this referral.

curetb.org